



The New York State

Balancing Incentive Program Initiative

Application for the State of New York

Submitted by:

The New York State Department of Health

February 26, 2013

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

February 26, 2013

Ms. Jennifer Burnett
Centers for Medicare & Medicaid Services
Disabled and Elderly Health Programs Group
7500 Security Boulevard
Mail Stop: S2-14-26
Baltimore, MD 21244-1850

Dear Ms. Burnett:

The State of New York is pleased to submit the enclosed application for the Balancing Incentive Program (BIP). As the single state Medicaid agency, the New York State Department of Health (the Department) will serve as the lead organization for BIP.

Participation in BIP will allow the State to build upon current efforts to rebalance the delivery of long term services and supports (LTSS) and to promote enhanced consumer choice. New York State will utilize the resources available through BIP to work toward streamlined eligibility processes, improved access and expanded LTSS for those in need. The State is confident our efforts under BIP will result in a more balanced and effective LTSS system that will ensure essential services are provided in the least restrictive setting.

Based on the projections of the provision of LTSS under BIP, as illustrated in Appendix B, New York State estimates it will receive approximately \$600 million during the project funding period (4/1/13-9/30/15). Specifically, New York State requests \$598,665,500 million based on such projections.

With the continued support and input of our vast network of stakeholders and state and local agencies, New York will implement the required structural changes under BIP, including creating a No Wrong Door/Single Entry Point system, a statewide core standardized assessment and a conflict-free case management system. New York remains committed to improving how LTSS are accessed and delivered throughout the state and we look forward to working with all those invested in achieving these goals.

The Department will serve as both the Oversight and Operating Agency for all Balancing Incentive Program services and structural changes. Mark Kissinger, Director of the Department's Division of Long Term Care, will serve as the Principal Investigator and primary contact person for the New York State BIP Initiative. In addition, Mr. Kissinger will serve as the Operational Lead for BIP, and work in conjunction with other partners to implement BIP. Please do not hesitate to contact Mr. Kissinger at 518-402-5673, or by e-mail at: mlk15@health.state.ny.us.

Sincerely,

Mr. Jason Helgeson, Medicaid Director
Office of Health Insurance Programs
New York State Department of Health

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Project Abstract

New York State plans to capitalize on its significant investment in home and community based long term services and supports (LTSS) across populations to further rebalance spending on LTSS through participation in the Balancing Incentive Program (BIP).

Participation in the BIP program will reinforce our ongoing efforts to improve access to home and community based long term care services for those with physical, behavioral health needs and/or intellectual disabilities throughout New York State. Through improved access to information and assistance, individuals will be able to make informed choices regarding services, settings and related issues.

To achieve these goals, New York will work to implement the three structural changes required under BIP, which will provide additional tools to streamline the LTSS eligibility and assessment process in New York. To meet these requirements, specifically, the State will:

- **No Wrong Door/Single Entry Point (NWD/SEP):** Enhance the existing NY Connects Network, which is currently operational in 54 Counties and serves as an information and assistance system for long term care services.
- **Core Standardized Assessment Instrument:** Continue implementation of the Uniform Assessment System (UAS-NY) and align with other agencies to ensure compliance with the core data set.
- **Conflict-Free Case Management Services:** Remediate any case management arrangements that do not align with the principles of BIP.

New York's Uniform Assessment System (UAS-NY) for older adults and/or physically disabled individuals is being phased-in beginning the first quarter of 2013 and is planned to be implemented by the end of 2014. The New York State Office for People with Developmental Disabilities (OPWDD) is also implementing a new assessment system that uses the same core data set and will be in its final phased by the end of the BIP project funding period. New York will review other assessments to ensure compliance with the required domains and other elements of BIP.

The BIP implementation plan is to investigate integrating an automated initial screen or self-assessment into the NY Connects system of NWD/SEP. This phase of BIP implementation is expected to be complete by the end of 2014. During the funding period New York State will carefully review its assessment and care planning processes to eliminate potential conflicts with BIP goals related to case management. As "Care Management for All" is implemented, New York will ensure that consumers have meaningful choice of providers, the opportunity to change care plans if dissatisfied and a fair, centralized appeals process to minimize any conflict of interest.

New York will use its increased federal funds to continue its successful rebalancing efforts to date including, but not limited to, the following:

1. Transitioning and diverting individuals who are elderly and/or disabled from institutional to community based settings;
2. Increasing community based opportunities for those with behavioral and intellectual disabilities;
3. Developing additional housing options to support high need/high cost Medicaid recipients in stable, sustainable and safe community environments; and
4. Expanding opportunities to address those needs which are critical to remaining in the community.

New York State Preliminary BIP Work Plan

GENERAL NWD/SEP STRUCTURE

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
General No Wrong Door/Single Entry Point Structure	Goal: Standardize information so that all individuals experience the same eligibility determination and enrollment process.				
	1.1. Develop standardized informational materials that NWD/SEPs provide to individuals	12/1/13	BIP team	Not Started	Informational materials
	1.2. Design enhancements to website (initial overview)	9/1/13		In Progress	Description of the system
	1.3. Design enhancements to website (final detailed design)	3/1/14		In Progress	Detailed technical specifications of web-based system, including navigation or "help" resources, if applicable
	1.4. Identify resources or procurement options to develop enhancements to website; Procure vendor (if necessary)	9/1/13		In Progress	Resources assigned or vendor contract signed
	1.5. Develop and Test new and enhanced tools in the website iteratively	3/1/14		Not Started	Development plan, Test plan. Beta test and results from both individuals and SEP staff
	1.6. System goes live	9/1/15		Not Started	System is fully operational
	1.7. System Updates	Semiannual beginning 9/1/15		Not Started	Description of successes and challenges

GENERAL NWD/SEP STRUCTURE

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
General No Wrong Door/Single Entry Point Structure	<u>Goal:</u> State has a network of NWD/SEPs and an Operating Agency; the Medicaid Agency is the Oversight Agency.				
	1.8. Identify the Operating Agency	9/1/13		In Progress	Name of Operating Agency
	1.9. Identify the NWD/SEPs	9/1/13		In Progress	List of NWD/SEP entities and locations
	1.10. Develop and implement a Memorandum of Understanding (MOU) across agencies	12/1/13		Not Started	Signed MOU
	<u>Goal:</u> NWD/SEPs have access points where individuals can inquire about community LTSS and receive comprehensive information, eligibility determinations, community LTSS program options counseling, and enrollment assistance.				
	1.11. Identify service area for all NWD/SEPs	12/1/13		In Progress	Percentage of State population covered by NWD/SEPs
	1.12. Ensure NWD/SEPs are accessible to older adults and individuals with disabilities	6/1/14		In Progress	Description of NWD/SEP features that promote accessibility
	<u>Goal:</u> The NWD/SEP system includes an informative community LTSS website; Website lists 1-800 number for NWD/SEP system.				
	1.13. Identify or develop URL	12/1/13		Complete	URL
	1.14. Develop and incorporate content	3/1/14		In Progress	Working URL with content completed
	1.15. Incorporate self-assessment into the website	3/1/15		In Progress	Working URL of Level I self-assessment and instructions for completion

GENERAL NWD/SEP STRUCTURE

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
General No Wrong Door/Single Entry Point Structure	<u>Goal:</u> Single 1-800 number where individuals can receive information about community LTSS options in the State, request additional information, and schedule appointments at local NWD/SEPs for assessments.				
	1.16. Contract for 1-800 number service	3/1/14		Not Started	Phone number operational
	1.17. Train staff on answering phones, providing information, and using the self-assessment	3/1/14		Not Started	Training materials
	<u>Goal:</u> State advertises the NWD/SEP system to help establish it as the “go to system” for community LTSS.				
	1.18. Identify resources or procurement options to develop outreach campaign; Procure vendor if necessary	1/1/14		Not Started	Resources assigned or vendor contract signed
	1.19. Enhance name recognition	6/30/13		Not Started	TBD
	1.20. Develop outreach plan	12/1/13		Not Started	Outreach Plan
	1.21. Implement outreach plan	3/1/14		Not Started	Develop and distribute materials associated with outreach plan
	1.22. Develop self-sustaining public awareness campaign	4/1/14		Not Started	Public awareness Plan Survey for recognition
	1.23. Implement public awareness campaign	4/1/14		Not Started	Develop and distribute materials associated with public awareness campaign

CSA/CDS

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Core Standardized Assessment	Goal: A CSA, which supports the purposes of determining eligibility, identifying support needs, and informing service planning, is used across the State and across a given population. The assessment is completed in person, with the assistance of a qualified professional. The CSA must capture the CDS (a Core Data Set of required domains and topics).				
	1.1. Develop questions for the self-assessment	3/1/14		In Progress	Self-assessment screening questions
	1.2. Fill out CDS crosswalk (see Appendix H in the Manual) to determine State's current assessments include required domains and topics	9/1/13		In Progress	Completed crosswalk(s)
	1.3. Incorporate additional domains and topics if necessary (stakeholder involvement included)	3/1/14		Not Started	Final assessment(s); notes from meetings involving stakeholder input
	1.4. Train staff members at NWD/SEPs to coordinate the CSA	9/1/14		In Progress	Training materials
	1.5. Identify qualified personnel to conduct the CSA	9/1/14		In Progress	List of entities contracted to conduct the various components of the CSA
	1.6. Regular updates	Semiannual after 9/1/14		Not Started	Description of success and challenges

CONFLICT-FREE CASE MANAGEMENT

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Conflict-Free Case Management	Goal: Establish conflict of interest standards for the Level I self-assessment, the Level II assessment and plan of care process. An individual's plan of care must be created independently from the availability of funding to provide services.				
	1.1. Describe current case management system, including conflict-fee policies and areas of potential conflict	9/1/13		Not Started	Strengths and weaknesses of existing case management system
	1.2. Establish protocol for removing conflict of interest	6/1/14		Not Started	Protocol for conflict removal; if conflict cannot be removed entirely, explain why and describe mitigation strategies

DATA COLLECTION AND REPORTING

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Data Collection and Reporting	Goal: State must report service, outcome, and quality measure data to CMS in an accurate and timely manner.				
	1.1. Identify data collection protocol for <i>service data</i>	9/1/13		Draft included in application. <u>Next steps:</u> <ol style="list-style-type: none"> 1) Protocol for reconciliation. 2) Complete development of templates. 3) Establish process document with appropriate staff. 	Measures, data collection instruments, and data collection protocol
	1.2. Identify data collection protocol for <i>quality data</i>	9/1/13		Identify models for quality measures. <u>Next Steps:</u> <ol style="list-style-type: none"> 1) Compare measures from 3 field-tested models. 2) Review 1915(c) measures for the opportunity to integrate quality measures throughout LTSS system. 3) Identify quality measures from each of the three models appropriate for BIP population. 4) Obtain organizational consensus. 5) Review/analyze data sources, programming resources and process options. (Including OPWDD/DOH/NYSOFA alignment). 6) Determine instruments or data sources which cover all populations and the degree of automation. 7) Determine best way to implement. 8) Estimate resources. 9) Document protocol(s). 	Measures, data collection instruments, and data collection protocol

DATA COLLECTION AND REPORTING

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Data Collection and Reporting	Goal: State must report service, outcome, and quality measure data to CMS in an accurate and timely manner.				
	1.3. Identify data collection protocol for <i>outcome measures</i>	9/1/13		Described current environment. Described preliminary outcome goals. <u>Next Steps (can be concurrent):</u> <ol style="list-style-type: none"> 1) Gather information on field-tested QOL surveys processes and programs. 2) Gather information on screen outcome information about access points to assure consistency of comprehensive information, eligibility determination for community LTSS, program options counseling, and enrollment assistance for potential entry into comprehensive assessments. 3) Gather information on assessment outcomes across populations, including service recipient and caregiver satisfaction. 4) Affirm outcome goals. 5) Analyze and develop tools and measures to fill the gaps. (Including OPWDD/DOH alignment). 6) Obtain organizational authorizations for proposed changes. 7) Document current process / automations. 8) Evaluate and determine best automation & process options. 9) Determine sampling and survey methods. 10) Document protocol(s). 11) Estimate resources. 	Measures, data collection instruments, and data collection protocol
	1.4. Report updates to data collection protocol and instances of <i>service data</i> collection	Semiannual		Not Started	Document describing when data were collected during previous 6-month period, plus updates to protocol

DATA COLLECTION AND REPORTING

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Data Collection and Reporting	Goal: State must report service, outcome, and quality measure data to CMS in an accurate and timely manner.				
	1.5. Report updates to data collection protocol and instances of <i>quality data</i> collection	Semiannual		Not Started	Document describing when data were collected during previous 6-month period, plus updates to protocol
	1.6. Report updates to data collection protocol and instances of <i>outcomes measures</i> collection	Semiannual		Not Started	Document describing when data were collected during previous 6-month period plus updates to protocol

SUSTAINABILITY

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Sustainability	Goal: Identify funding sources that will allow NY to build and maintain the required structural changes.				
	1.1. Identify funding sources to implement the structural changes	9/1/13		In Progress	Description of funding sources
	1.2. Develop sustainability plan	9/1/14		In Progress	Funding sources and estimated annual budget necessary to maintain structural changes after award period ends
	1.3. Describe the planned usage for the enhanced funding	9/1/13		In Progress	Detailed description of how the State will use the enhanced funding earned through the program

Application Narrative

Section A. Understanding of Balancing Incentive Program Objectives

New York State has a long history of serving individuals who have functional and/or medical needs in their homes and communities as an alternative to institutional care. For over 30 years, Medicaid recipients in New York State have had access to a state plan personal care program, as well as a consumer-directed personal care model, that is the most generous in the nation. Our State Medicaid Plan also includes adult day health care, home health care, private duty nursing, hospice, and assisted living. These benefits are offered to individuals who can safely be cared for in the community without waiting lists or other limitations on the provision of their long term care. New York also has strong models in which behavioral and developmental health services are offered in the community through the Office of Mental Health (OMH), the Office of Alcohol and Substance Abuse Services (OASAS) and the Office for People with Developmental Disabilities (OPWDD). These agencies operate systems that are among the most extensive in the nation in terms of coverage and scope of services.

New York has also made use of the federal 1915(c) Home and Community Based Medicaid waivers available through the Social Security Act. In the late 1970's, we established the Long Term Home Health Care Program (also called Nursing Home Without Walls) to serve individuals of all ages. Since that time New York developed additional waivers to address the needs of specific populations who choose to receive long term care in their home as an alternative to institutional care. These waivers serve children with serious emotional disturbance (administered by the OMH), those with developmental disabilities (administered by the OPWDD), adults with traumatic brain injuries (TBI Waiver, administered by the Department of Health), adults with physical disabilities and senior citizens (the DOH Nursing Home Transition and Diversion Waiver), children with serious medical and/or functional needs (Care at Home Waivers administered by the DOH and the OPWDD) and children with functional and/or medical needs who live in foster care (the Office of Children and Family Services' Bridges to Health Waiver). Through these waiver programs New York State serves nearly 100,000 Medicaid recipients. In addition, New York State participates in the federal Money Follows the Person (MFP) Demonstration, which has successfully transitioned nearly 1,000 persons to community settings to date. MFP participants are enrolled and receive State Plan and other long term services and supports (LTSS) through the New York State Department of Health (DOH) NHTD and TBI waivers. In conjunction with this submission, New York State is revising its Money Follows the Person (MFP) Operational Protocol to more explicitly incorporate individuals with intellectual and developmental disabilities.

New York State offers robust home care services through its State Medicaid Plan that are available to Medicaid-eligible individuals across the state based on their medical and functional needs to allow them to remain in their homes and communities or to transition out of institutional settings. As a result of these options in New York State, significant resources are devoted to the provision of long term care in community-based settings when compared to those resources expended on long term care in institutional settings. Based on federal reporting data in FFY 2009, New York had a community-based LTSS ratio of 46.7%. In addition, many services are offered to functionally and cognitively impaired older adults through the aging network that defer the need for Medicaid funded LTSS, including the Expanded In-Home Services for the Elderly Program (EISEP), Community Services for the Elderly (CSE) and Supplemental Nutritional Assistance Services Program (SNAP), and NY Connects: Choices for Long Term Care and services supporting informal caregivers.

Most individuals want to receive needed medical services and assistance with their functional needs in their homes and communities, and often it is more efficient and effective to provide such services in these settings. New York has a robust system of long term care, a broad network of highly qualified providers and engaged advocates that partner with policy makers to develop improved services. New York is committed to leveraging our significant investment in LTSS to increase the ratio of expenditures on community based care to institutionally based care to 50% and beyond, and is confident that changes underway in the state, along with participation in the Balancing Incentive Program (BIP), will help achieve that goal.

Additional financial support through the closure of institutions, and the expansion of services under a planned Community First Choice (CFCO) option will further rebalance expenditures toward community based LTSS in New York State.

Commitment to BIP Requirements

New York State will capitalize on its significant investment in LTSS across populations by implementing BIP. While New York offers a broad range of long term care services to those in need of medical and/or functional assistance in their home or community, discharge planners, social workers and others often seek to enroll the individual in the program or waiver that relates to his or her diagnosis or disability rather than investigate all available options. This often results in people being placed in programs or waivers that may limit their access to needed services, thus creating a system of silos.

BIP requirements including a No Wrong Door/Single Entry Point system will help New York ensure that consumers are aware of their options across the spectrum of services offered to various populations in the state. It will further ensure that consumers, discharge planners and family members receive consistent information regardless of how or where they access long term care information. Finally, it will ensure that financial and functional eligibility determinations are made quickly and fairly so that enrollment in services in community-based settings is not more burdensome than enrollment in an institutional setting.

No Wrong Door/Single Entry Point (NWD/SEP)

To achieve these goals, New York State plans to enhance its existing NY Connects Network, which is operational in 54 counties in the State and acts currently as an information and assistance system for LTSS. Each county has implemented this program adhering to a set of 22 standards while operationalizing based on county determined organizational structure. Consumers can access information about LTSS via the website, www.nyconnects.ny.gov, in their homes via home visit or at a community location. Links on the website also allow consumers or their representatives to determine whether they may be eligible for a wide variety of public assistance programs, including Medicaid. There is currently a short “screen” that information and assistance representatives at local offices can use to determine services for which an individual who calls or visits may be eligible. As part of its BIP participation, New York State intends to enhance this system to more clearly include all populations that may have long term care needs, as the current system focuses on older adults and physically disabled populations; review the current screen for appropriateness as a Level I screen/self-assessment envisioned by BIP; investigate the possibility of automating the screen and integrating the financial eligibility screen; and ensure that all offices that are part of the NY Connects and other NWD/SEP locations throughout the state use NY Connects information and tools to ensure consistent information about long term care available in the individual's community.

Currently, NY Connects uses local offices of aging in partnership with local departments of social services in a network of local access points for information and assistance. Under its BIP plan, New York intends to add Independent Living Centers, OPWDD's regional offices, OMH regional offices and other partners to this network of local "doors" to ensure that consistent information is provided across populations and that consumers truly have no wrong door access to New York's considerable array of LTSS. NY Connects already offers a local or toll-free number to individuals in their county to access long term care (LTC) information and assistance. These resources will be enhanced to provide all populations in need of LTSS with both information and assistance regardless of how they access this system. New York's ideal is for the consumer to be able to learn about their options through a website, telephone call or in person visit to a local office where they can consult a well-trained, informative representative. The consumer should be able to choose from among the services and programs for which he or she is eligible based on his or her specific needs and goals. Enrollment into these services and programs should be timely and seamless at the consumer level regardless of the agency that oversees them.

Core Standardized Assessment(s)

New York has also made significant strides in implementing a Uniform Assessment System (UAS-NY) for its elderly and/or physically disabled population using the interRAI Assessment Suite. In addition, OPWDD is implementing a similar core assessment based on the same assessment suite. These assessments will use the same general domains with population specific additions to develop a statewide data set that can be used to plan and improve services, predict trends and report progress. As part of its BIP plan, New York State will assess whether the population specific assessment used by OMH meets the domain requirements of a Core Standardized Assessment.

Conflict-Free Case Management

The MRT strategy of "Care Management for All" may require additional standards to be developed within managed care to implement a Conflict-Free Case Management System under BIP. New York State is committed to ensuring that consumers have options, that these options are presented to consumers clearly, and that there is an appeals process in place to assure those dissatisfied with their placement have alternatives. Currently, New York's managed long term care standards allow consumers to transfer to other plans without any lock-in period.

Section B. Current System's Strengths and Challenges

New York State's greatest strength is that across all populations, consumers are offered a broad scope of services to address their medical and/or functional long term care needs. A significant challenge is that these services and programs are often fragmented, may not be consistently offered across the state and may not be known to consumers who are placed into different programs. New York plans to use its participation in BIP and other efforts including MFP and CFCO, to reduce these silos of care, improve the patient-centered approach of care planning, ensure that services are available across populations regardless of how one accesses information, and improve the availability and accessibility of consistent information about LTSS options in the various communities of New York State.

Accessing LTSS for Older Adults and/or Physically Disabled Populations

The current LTSS system in New York for older adults and persons with disabilities has many strengths. Starting in April of 2013, a new uniform assessment system (UAS-NY) will be used by professionals to

assess individuals in eight different programs and services: Assisted Living Program, adult day health care, personal care and CDPAP, Care at Home Waivers I and II, Managed Care/Managed Long Term Care, Long Term Home Health Program, NHTD and TBI Waivers.

For more information, see:

http://www.health.ny.gov/facilities/long_term_care/docs/2012-06-26_ny_beta_project_update.pdf.

These Medicaid services are available to any eligible individual who requires them to remain safely in their homes and communities across all populations and the waiver services are available without waiting lists in New York. In implementing a single assessment for the provision of community based LTSS for this population, New York anticipates reducing regional variation due to assessor bias and standardization of assessment tools in programs and services. Separate efforts under the MRT seek to address workforce shortages, which is another major barrier to consistent community-based placements.

For more information on this initiative see:

http://www.health.ny.gov/health_care/medicaid/redesign/workforce_flexibility.htm

New York State's comprehensive move to Care Management for All is another strength that transcends populations of individuals in need of LTSS. By ensuring that the primary, acute and long term care needs of individuals are coordinated and managed, New York State anticipates meeting the triple aim of cost containment and critical improvements in both quality of care and health outcomes. For older adults and/or physically disabled populations, this typically means moving from a fragmented fee-for-service system in which some of an individual's needed LTSS services were provided through a waiver, the state plan or a combination of both, often without consideration of his or her acute or primary care needs. This transition is underway in New York with those individuals over the age of 21 who are dually eligible for both Medicaid and Medicare who need LTSS for more than 120 days. Starting in September of 2012 individuals were mandated to select a managed long term care plan if they reside in one of five current mandatory counties (New York, Richmond, Queens, Kings, and Bronx). Starting in January 2013, this approach was expanded to Nassau, Suffolk and Westchester counties. Over the BIP period additional groups will be transitioned to care coordinated settings including managed care/managed long term care plans and health homes, depending on their care needs, their current placement and where they live. New York's Proposed Demonstration, Fully Integrated Duals Advantage Program (FIDA) is based on this foundation and the support of CMS and its Office of Coordination of Medicare and Medicaid. New York was one of the 15 planning grant states and is currently in the process to initiate its demonstration in 2014.

More information on the FIDA, the managed care aspect of the duals project, may be found at this link:

http://www.health.ny.gov/facilities/long_term_care/docs/2012-05-25_final_proposal.pdf.

Information about New York's existing Managed Care program may be found at:

http://www.health.ny.gov/health_care/managed_care/index.htm.

The recently approved 1115 Demonstration Amendment to the Partnership Plan and information about New York's prior demonstrations to mandate managed care for certain populations may be accessed here:

http://www.health.ny.gov/health_care/managed_care/appextension/.

Accessing LTSS for Individuals with Behavioral Health Disabilities

Individuals with behavioral health disabilities have access to New York's wide array of state-plan home and community based services and supports for which they are financially and functionally eligible. In addition, there are individuals who have both behavioral and/or physical or developmental disabilities currently being served in waivers operated by DOH and OPWDD. OMH also operates a waiver for children with serious emotional disturbance who are at risk of placement in institutional settings. The population served by OMH, like New York's other populations, is moving toward Care Management for All.

The MRT recommendations related to this transition are described at the following link:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf (pp. 18-20).

The MRT Behavioral Health Workgroup's Recommendations can be found here:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtcompanion.pdf (pp. 18-90).

Key to this transition will be the establishment of Behavioral Health Organizations (BHOs), which will work alongside the Managed Care plans already coordinating the primary and acute health care needs of many individuals with mental health and/or substance abuse needs to assure their access to fully integrated care. The initial effort to establish BHOs sufficient to address the needs for all those with mental health/substance abuse needs will focus on services and supports paid by Medicaid fee for service, particularly those aimed at post-release transitions. This will help reduce the percentage of individuals who are readmitted to psychiatric units within 30 days (20%). Eventually, the BHOs are expected to be risk-bearing as are other care coordination models. The MRT also concluded that there is an over-reliance on State psychiatric hospitals, adult homes and nursing homes in serving those with behavioral health issues, partly due to the system's inability to assign responsibility for integrated community care.

The MRT recommendations include reinvestment of some of the savings related to improved care coordination to support critical issues such as housing, employment services, peer support and family support. Additional recommendations are well aligned with BIP imperatives including a “no wrong door” approach so that no matter where patients/consumers enter the system, they are guided to the right provider, and that standardized screening tools should be used. Recognizing the diversity of the subset of Medicaid recipients who have behavioral health issues, the MRT recommendations also focused on the need to ensure that for older adults, care coordination will require interface with home health services, adult day care, and a heightened sensitivity to physical health needs.

As the State has started implementing these recommendations, the Department of Health is working closely with our sister agencies and stakeholders to determine how BIP resources may be tapped to assure that as those with behavioral health needs are integrated into Care Management for All, the goals of BIP are considered and supported.

Accessing LTSS for Individuals with Intellectual and/or Developmental Disabilities

A significant strength is New York's history of grassroots development in which engaged parents, individuals with developmental disabilities alongside service providers and state leaders work to create

the extensive menu of supports and services for individuals with a wide range of needs and their families. The strong sense of partnership among stakeholders is a resource New York State has tapped throughout its history and most recently as it has carefully sought insight and support for broad scale system improvements aimed at increasing the person-centeredness and accordingly, the system's effectiveness and efficiency, and the accessibility of long-term, community-based services to people with developmental disabilities within the People First Waiver.

New York State is working with CMS on a detailed work plan related to its transformative agenda regarding deinstitutionalization, employment and self direction. In addition, on April 1, 2013 OPWDD and DOH will submit to CMS a 1915(b) application and a 1915(c) amendment that describes our plan for ensuring the home-like quality of all provider-operated homes where HCBS waiver residential habilitation services can be provided, and other operational elements that comply with the intent of the 1915(i) NPRM. The new application will also outline new/revised services that will expand opportunities for self direction and integrated employment. This transformation in the provision of LTSS goes hand in hand with BIP objectives and New York's participation will assist us in the following activities:

- Develop Community Based Capacity for an effective crisis prevention and response system utilizing the nationally recognized Systemic, Therapeutic, Assessment, Respite and Treatment (START) model. START is a program created by the Institute on Disability/University of New Hampshire.
- Develop and implement a uniform specialized assessment system, based on the interRAI intellectual disability tool to better inform care planning and access to services across the state for persons with intellectual and developmental disabilities. Although specialized for persons with intellectual and developmental disabilities, this tool shares common data elements with the UAS-NY and therefore is an important building block toward truly integrated care planning and information sharing across aging and disability services.
- Develop and implement a statewide training and supports program for persons with intellectual and developmental disabilities who are interested in self-direction. With this additional support, New York will offer the option to self-direct to no less than 10,000 persons entering the specialized care management plans and transitioning from closed institutions, guided by the person-centered assessment.
- Adopt practice guidelines for care coordinators serving individuals with intellectual and developmental disabilities based on the Council on Quality and Leadership (CQL) personal outcome measures and annually assess managed care provision of care coordination using personal outcome data.
- Reorganize OPWDD's regional office structure to better meet the needs of the system today and in anticipation of the future where access to services and support of the transition to managed care requires a dedicated focus at the local level.
- Close most campus-based institutions serving individuals with intellectual and developmental disabilities and provide person-centered planning for the individuals leaving institutions that will result in a person-centered plan of service that will meet their housing and other service needs in the most integrated setting appropriate to those needs.

- Reinvest approximately \$166 million and expand community living for people with developmental disabilities through the development of community-based services for individuals now living in developmental centers in accordance with a transition plan that will be developed by New York State and CMS. New York is committed to transform its system by virtually eliminating the use of ICF/IIDs and developing services and supports to meet the needs of individuals who may have complex medical and/or behavioral needs in integrated, community settings. A specific element of this reinvestment will increase access to non-institutional LTSS, benefit Medicaid enrollees with I/DD and fund services that are eligible for Medicaid match. Specific items include:
 - Supporting expanded peer counseling and support services that are first funded through New York's MFP program. This service will link individuals living in institutions with individuals who have successfully transitioned to community settings.
 - Expanding peer housing counselor services, to assist individuals with accessing housing opportunities in their community.
 - Working with stakeholders and community members to accept and fund proposals to develop services that provide opportunities for choice of community support options for individuals with the highest level of need.
 - Funding and developing a specialized rate cell to support the transition of individuals from institutions to community living when the individual opts to have his or her community-based supports coordinated by a managed care entity.
 - Implementing a self-directed approach in which individuals and their designated representatives may fully control the hiring, discharge, supervision, performance review, distribution of goods and services, and performance raises of their workers within their authorized budget allocation.

OPWDD, in cooperation with the Department of Health, will structure extensive outreach and education to individuals in all types of institutional settings, including developmental centers and community based ICF/IIDs. Referrals from numerous sources will initiate individuals to the MFP process of state-assisted enrollment into the HCBS waiver, and transition coordination provided by contracted transition coordination entities. These contracted transition coordinators will work closely with individuals, assisting them to select a Medicaid Service Coordinator or a care coordinator (within managed care) and understanding the service options available to them and how transition will occur. The transition coordinators will also provide transition planning services, develop and deploy a transition plan for each individual (including identification of acceptable residential settings and needed transportation supports), and work closely with the individual to identify a circle of support to assist in the care planning process. The transition coordinators will also fulfill important recording, tracking and reporting requirements related to the MFP program.

In fulfilling its system transformation, OPWDD will transition nearly all of the individuals who currently reside in institutional settings into community settings. Not every individual who transitions will be eligible to participate in the MFP program. Nonetheless, each transitioning individual will have receive transition coordination and be provided access to consultation from peer advocates, housing counselors, self direction specialists, and employment specialists to ensure that the unique needs and interests of the

person are supported. Other specialty areas of consultation to facilitate a person centered support plan development will be initiated as needed. BIP funding will build upon the infrastructure and resources that will be put in place to expand NYS's MFP program to include individuals with I/DD.

Other Rebalancing Initiatives and the Role of BIP

Medicaid Redesign/Olmstead

In 2011, Governor Andrew Cuomo established a Medicaid Redesign Team (MRT), charged with finding savings in the State's \$54 billion Medicaid program while improving both quality of care and health outcomes. The goals of the MRT align with the CMS triple aim of cost containment, better quality and improved health outcomes for Medicaid and/or Medicare recipients. The MRT team brought together statewide stakeholder workgroups from across the spectrum of aging and disability service systems that have been informing policy-making since the beginning of Governor Andrew Cuomo's administration. Critical system redesign issues were explored through the MRT workgroups focusing on long term care, behavioral health and housing issues.¹ Within the developmental disability service system, stakeholder groups have been integral to the system redesign associated with the People First Waiver, the most recent discussions focusing on advocacy and access issues related to community based care.²

The work of all of these groups will inform the decision-making and leadership that will be provided by the Olmstead Plan Development and Implementation Cabinet. Governor Cuomo created this cabinet in December 2012, bringing together top state-level leadership to make recommendations to the governor concerning the development, implementation, and coordination of an Olmstead Plan for the State of New York.³ The cabinet will establish clear timelines and milestones for New York to meet the Olmstead objectives of providing meaningful community living for people with disabilities and elders. The plan that is ultimately developed will reflect New York's vision of choice and opportunity for individuals and deploy the deliberate development of more accessible, coordinated and effective long-term supports in local communities. Thus, with the leadership and guidance of the cabinet, New York will make real the objectives of the Olmstead decision using the resources and structure provided by BIP.

Care Management for All

One of the most significant reforms that has emerged to support community living relates to Care Management for All, including a transition of long term care consumers to managed care. New York State has had a successful managed long term care system since the mid 1990's. The MRT plan is using that program to build out a care management strategy for dual eligible consumers. Specifically, chronically ill and/or disabled individuals in various Medicaid programs and those dually eligible for both Medicaid and Medicare are being provided with the choice to join managed care and managed long term care plans. Already, New York State is requiring Managed Care Plans and Managed Long Term Care Plans to offer the range of long term care services included in the State Medicaid Plan to their members, including the Consumer Directed Personal Care Program (CDPAP). Dually-eligible adults over 21 who

¹ Citation MRT workgroup recommendations:
http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtcompanion.pdf.

² http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/targeted_work_teams

³ http://www.opwdd.ny.gov/opwdd_community_connections/misc/press_releases_and_important_documents

require home and community based services for more than 120 days are already transitioning to managed long term care in certain counties in the State, as are those in receipt of CDPAP services.

The move to comprehensive care coordination for people with intellectual and developmental disabilities is being developed under the proposed People First Waiver. The People First Waiver will establish a specialized managed long term support services model to promote comprehensive care coordination across all of the person's needs in order to better integrate habilitative and behavioral health needs and promote service delivery in the most integrated setting. The hallmark of care coordination is the use of person-centered methodologies to create an individual's plan. The quality of care coordination will be assessed based on the support and promotion of key quality outcomes for the individual and this information will be aggregated to assess plan and system level performance.

Already, over four million of the approximately five million Medicaid eligible New Yorkers are enrolled in some kind of care management arrangement, either through mainstream managed care, as a result of belonging to a mandated population or through voluntary enrollment; participation in one of New York State's three managed long term care options: Medicaid Advantage Plus, P.A.C.E. or a Managed Long Term Care Plan; enrollment in a health home; or through another care management model. Additional Medicaid recipients are being transitioned to care coordination models and by 2016 Care Management for All should be a reality in NYS. The impetus behind this transformation in the delivery of care to Medicaid recipients is predicated on the belief that care coordination is key to addressing inefficiency and inefficacy of the currently highly fragmented health care system across primary, acute, behavioral and long term care needs. New York's experience with managed care has shown improvements in access to needed care, reduction in emergency room and inpatient utilization, and improved health outcomes. Furthermore, care management models allow New York State to build in incentives to make community based care the default after periods of hospitalization or short-term nursing facility care, improve the quality of care, and work toward better health outcomes.

New York believes that the transition to managed care and managed long term care is consistent with the goals of BIP and other federal incentive programs such as the Community First Choice Option (PL 111-148, §2401): allowing consumers more choice of providers, aligning services with the needs of the consumer determined by a person-centered care planning process, and ensuring that individuals are aware of their options so they can make informed choices from the range of options appropriate to their needs. The requirements of BIP will help New York State achieve these goals by ensuring that no matter how a consumer approaches his or her search for needed functional and/or medical services that he or she receives consistent information about relevant options, that his or her financial and functional eligibility for such services is determined quickly and fairly, and that his or her enrollment into needed services for which he or she is qualified happens as seamlessly as possible.

New York's participation in BIP will help assure that the transition to Care Management for All will maximize the provision of LTSS in integrated community settings to the greatest extent possible. It will help assure that individuals are fully aware of their options to remain at home or in integrated settings within the community instead of assuming that a nursing home is the most appropriate placement, regardless of where the individual lives in the state. Individuals seeking LTSS will receive consistent information through the NWD/SEP and be referred to care management models that are incentivized to provide case management and other services consistent with quality and outcomes goals established by the state to meet the triple aim. BIP will be a critical vehicle in our efforts to bend the cost curve and improve the quality of both service delivery and health outcomes through this overarching initiative.

MFP

Through New York's participation in the Money Follows the Person Demonstration several projects have been initiated to increase the number of persons who can be moved back to the community from institutional settings. Statewide outreach and education programs to individuals living in nursing homes is in its 3rd year of operation as well as a statewide housing project to educate landlords, housing authorities and individuals to increase the availability of accessible housing. These projects increase the availability of accessible, affordable housing to address what is often the biggest barrier to transition from institutional placement; support the transition of individuals from acute care facilities directly to community-based settings rather than to an institutional setting; and support the transitioning of those with behavioral health issues back to the community.

Other rebalancing initiatives commenced or expanded through New York's participation in MFP include the NY TRAIID demonstration, which lends needed assistive devices and durable medical equipment to individuals transitioning to the community until the waiver in which they are participating has them available and additional funding for the New York State Accessible Housing Registry (www.NYHousingSearch.gov), a web-based registry of accessible rental properties that is searchable by location or by income, age and/or disability. These projects would benefit from New York's participation in BIP by ensuring that more people are aware of the programs and services available in the community to address an individual's needs. In addition, BIP funds combined with MFP efforts underway may support new diversion efforts as well as the current transition programs.

Concurrent with its application to participate in the BIP, New York State has amended its MFP Operating Protocol to clearly include individuals with intellectual and developmental disabilities. As a result, The MFP demonstration will target all nursing homes and ICF/IID facilities in New York State. OPWDD's strategies for recruiting individuals residing in non-campus-based ICF/IIDs and SNFs will be statewide, while the strategy for recruiting individuals in campus-based ICF/IIDs will be geographically targeted in coordination with the planned closure and downsizing of current institutions.

Beginning in 2013, OPWDD will initiate statewide outreach and education of its staff, voluntary service provider agencies, individuals with developmental disabilities, their family members and other stakeholders about the MFP demonstration and the ability for individuals to participate and experience more integrated residential settings. OPWDD regional PASRR Coordinators will supplement the outreach activities of the NHTD and TBI waiver staff and RRDS to individuals and staff in SNF residences. In addition, OPWDD will establish a peer counseling network under contract with the Self Advocacy Association of New York State (SANYS) to provide extensive outreach that will reach all institutions, individuals, and staff. These peers will use a variety of materials such as videos, posters, informational flyers and handouts to inform potential MFP participants and other parties of the MFP demonstration and Medicaid Home and Community-Based Long Term Care Services, including options for self-direction.

Supportive Housing

Another significant recognition by the MRT in its efforts to bend the Medicaid cost curve while improving quality and health outcomes is that in order to successfully reach many high-need, high cost Medicaid recipients, it is necessary to assure that they have safe, sustainable and stable housing. Homelessness or the risk of homelessness, among the diverse populations reliant on Medicaid for their primary, acute, behavioral and long term health care threatens the success of any treatment and almost assures relapse. This increases costs due to overuse of emergency departments and inpatient care and wastes precious resources due to lack of follow-up. Coordinated care through Care Management for All

will go a long way toward improving this situation, but even with better coordination it will continue to be difficult to serve individuals without a stable place to call home.

Toward that end, the MRT Affordable Housing Workgroup and the MRT approved recommendations to enhance the state's capacity of supportive housing. Among these recommendations was a dedicated fund, which is currently comprised of state-only dollars pending federal approval of matching funds, to support the construction of additional units of supportive housing across the state and to support the ability of high-need, high-cost Medicaid recipients across the disability spectrum to be housed. The state provided \$75 million toward that end in last year's enacted state budget and the 2013-2014 Executive Budget proposal calls for another \$75 million with an additional \$4 million in support of this initiative. In this way the State is helping to build capacity for community based placements. Additional capacity building activities are recommended in the MRT Affordable Housing Work Group's recommendations, which were adopted by the MRT, and are underway in New York.

More information can be found by following the link here:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtcompanion.pdf (pp. 361-414).

Challenges

The provision of long term care in New York City is much different than the provision of services to meet the same needs in rural upstate counties, particularly with regard to community vs. institutional care. Individuals in NYC are far more likely to be served in their homes and communities than in institutions. This is due to many factors; striking variances in the availability of a direct care workforce, the greater availability of institutional care upstate, economies of scale and other factors such as the availability of transportation and housing. Even where a single system of information and assistance exists (NY Connects), it is organized differently in each county based on a set of standards and is not available in the boroughs of New York City, which has developed its own system of referral and information. Conquering these factors, while preserving what works well in New York's 62 counties, is a considerable challenge.

New York is already implementing a statewide system of access points providing the same information across populations regarding the availability of home and community based LTSS and seamlessly enrolling qualified individuals into MC/MLTC plans or other care management models, such as health homes. However, despite our successful efforts in rebalancing LTSS to support more services in home and community based settings, New York State has not done enough to ensure that consumers consistently throughout the state know their options; nor do all discharge planners, social workers, nurses and other primary sources of referrals to nursing homes and other institutional settings realize the full scope of programs and services available to ensure the provision of appropriate care in the community. To improve the ability of consumers to navigate New York State's complex system of long term services and supports, it is necessary to ensure widespread awareness of the full scope of services available to any functionally and financially eligible individual who is aged and/or physically, developmentally or behaviorally disabled. This would mitigate some regional biases in the types of services offered to individuals and assure that consumers are fully aware of their options across all state plan and waiver services for which they are eligible. Finally, as we move toward a "Care Management for All" model, it is important to assure that individuals with functional and/or medical needs across the state have access to the full spectrum of services to meet them.

New York State, through its participation in BIP, will leverage its many successes to address these challenges by enhancing its existing NY Connects system of LTSS information and assistance to a truly statewide system of information and assistance. Under the NY Connects umbrella, the state will ensure that all programs and services offering assistance to those with LTSS needs across all populations will be highlighted in one place so that consumers are fully aware of their options. The NY Connects website will include a single 1-800 number in addition to the regional numbers currently included to ensure one-stop access. An integrated Level I Screen/Self-Assessment will inform individuals seeking answers about what LTSS they or a family member may be eligible for and provide them immediate access to more information about those services, including where to go for a more comprehensive Level II/UAS-NY or comparable functional needs assessment. The self-assessment will include a financial eligibility screen that will provide consumers with information about what assistance may be available to them in paying for needed LTSS. In this manner, consumers of LTSS in New York State will be empowered to direct their LTSS fully armed with the knowledge of the full scope of available services and supports for which they are eligible.

Section C. No Wrong Door/Single Entry Point Partners and Roles

New York has a rich tapestry of local offices, agencies and providers such as Independent Living Centers where individuals can go to learn about long term care options in their community. A network comprised of these many resources will ensure that no matter where people go to learn about their options, they are provided consistent information. Under the BIP work plan, New York will work toward an integrated website that provides information and assistance through the NY Connects website and others, a single 1-800 number, and at the SEP nearest their home which will be staffed by well-trained and informed individuals ready to assist consumers with initial assessments.

OPWDD is a partner with the New York SEP system and its six regional offices throughout the state serve as regional hubs for specialized service access and eligibility services. Resources to support eligibility determinations are available on the OPWDD website at:

http://www.opwdd.ny.gov/opwdd_services_supports/eligibility/documents/guide_to_eligibility_assessment_resources_final.

Additionally, OPWDD's CHOICES platform provides an electronic provider gateway for voluntary and state providers to enter key transactions such as needs assessment data through on-line transaction processing via the Internet. CHOICES provides a solid and existing foundation on which to build effective cross-system coordination, information sharing and improved accessibility to services and improved efficiencies. New York will describe these options fully in developing its NWD/SEP system in its final work plan.

Section D. No Wrong Door/Single Entry Point Person Flow

NY Connects will be enhanced to provide consistent information about LTSS options across populations through the website, via local and/or toll-free numbers and/or in person at SEPs throughout the state.

As described above, New York will capitalize on its wealth of local access points and coordinate information so that consumers across the state have the information they need to learn more about LTSS for which they may qualify and enroll in programs and services knowing that they have chosen them from among all those offered to address their specific needs. Empowering the consumer to be well informed about the programs and services for which he or she may be eligible across the many platforms possible

in New York State is the state's primary goal of participation in BIP. Creating an interface that allows consumers to see all of their options regardless of which agency oversees the program or service and permitting a self assessment to determine which of these services they may be eligible for will ease access to the array of LTSS in New York and assure that consumers have consistent information no matter where they live or how they access such information.

As required in BIP, the consumer will be able to access consistent information about LTSS in his or her community through an informative website (NY Connects), a statewide 1-800 number (to be developed to work with the NY Connects network of NWD/SEP entities), or by visiting a local NWD/SEP office around the state. New York State's goal is to empower the consumer to direct their own search for services through an information interface that provides centralized information about all the options that exist in the state to meet the LTSS needs of its residents. A self-assessment integrated with an existing financial eligibility screen will allow individuals to easily see what LTSS may meet their needs and provide immediate information about those services and any financial assistance that may be available to him or her. In addition, existing resources will be evident to eligible consumers who want additional help understanding their options and/or enrolling in programs and services.

Section E. No Wrong Door/Single Entry Point Data Flow

Individuals will be able to receive information about services, programs and SEP locations tailored to their particular situation based on data that either they or their SEP coordinator put in the self-assessment tool via the website. Individuals can do this as often as they want to reflect changing circumstances. Individuals and/or SEP coordinators will also be able to receive information about financial eligibility based on data they enter in the financial eligibility screening tool via the same website.

Once an individual presents to a SEP or managed care organization, coordinators from those organizations can access tools from the website and tools or data from the financial eligibility and comprehensive assessment systems (UAS-NY or Core Standard Assessments). The UAS-NY will allow assessors or coordinators to access and search the data in the financial eligibility system (via a real-time interface) to find those who are potentially eligible or eligible for Medicaid. If such a search is fruitful, there will be a feature which allows the assessor or coordinators to auto-populate the comprehensive assessment system with Medicaid eligibility information, active addresses and other demographic data. SEP local district coordinators will also be able to access the web-based UAS-NY to search for and auto-populate an individual's data.

Data from the UAS-NY will be replicated, structured and stored in the Data Warehouse as well as within their primary sources.

Section F. Potential Automation of Initial Assessment

As part of its participation in BIP, NYS will investigate the automation of an initial self- assessment that integrates both financial and functional screens. Ideally, individuals will be able to use the website or discuss their needs with local NWD/SEP staff accessed through the 1-800 number or in person to get immediate feedback on services, programs and/or financial assistance for which they may be eligible. New York State already has automated financial screens that can be maximized to coordinate through the NY Connects LTSS Interface.

Section G. Potential Automation of Core Standardized Assessment

OPWDD has selected the interRAI Integrated Assessment Suite to serve as the core of the needs assessment process within the People First Waiver system reforms. The interRAI has dozens of domains and multiple items per domain to fully inform a person-centered care planning process. Establishing a new service system that will ensure quality support of people with developmental disabilities across all areas of their life interests and needs requires an assessment process involving comprehensive domains that is sensitive enough to effectively identify an individual's unique medical and behavioral health needs. Assessment domains and items on the interRAI ID are repeatedly tested and revised to ensure high reliability and validity.

Use of the interRAI Assessment Suite will link OPWDD's service system with the New York State Department of Health (DOH) and a unified data warehouse that supports establishment of "No Wrong Door" access to services. The DOH is currently in the beta testing phase of its Uniform Assessment System (UAS) with the interRAI Community Health Assessment (CHA) at its core.

OPWDD is initiating the testing of an electronic application to test the design and delivery of its assessment suite of tools. Once the testing is complete, within the next 18 months, OPWDD will begin full-scale roll out on a statewide basis to inform care planning and promote equitable reimbursement through a managed care service delivery system.

The UAS-NY, which is a comprehensive assessment tool currently being developed for automation for DOH long term care programs is scheduled for pilot and implementation in early 2013. The OPWDD has identified a comprehensive assessment tool for its programs which uses 60% of the core assessment domains and scales inside the UAS-NY. The OPWDD tool is augmented by supplemental assessments which are triggered based upon various individual circumstances. OPWDD is currently conducting case studies using this comprehensive tool while developing a temporary automation to capture data from the case studies. This temporary automation is expected to be available in early 2013. Once the case study period is over in early 2014, the temporary OPWDD automation will be enhanced to the permanent solution (OPWDD-CAS) and then unified with the UAS-NY.

As part of its BIP final work plan, NYS will investigate the other assessments used in the state to determine the value of automation.

Section H. Incorporation of CSA in the Eligibility Determination Process

Once identified as potentially eligible, individuals can be assessed through UAS-NY, OPWDD's CAS, Health Homes Assessment or other core assessment to determine their functional needs and assist in care planning. As discussed above, the UAS-NY will allow assessors or coordinators to access and search the data in the financial eligibility system (via a real-time interface) to find those who are potentially eligible or eligible for Medicaid. If such a search is fruitful, there will be a feature which allows the assessor or coordinators to auto-populate the comprehensive assessment system with Medicaid eligibility information, active addresses and other demographic data. SEP local district eligibility coordinators will also be able to access the web-based UAS-NY to search for and auto-populate an individual's data.

NYS will look into the other assessments used in the state to determine opportunities to integrate or interface them with the financial eligibility system.

Section I. Conflict Free Case Management

The goals of Care Management for All in New York includes assuring that individuals receive high quality, publicly supported health and long term care services in the most efficient manner to support their desired outcomes. Key to this goal is appropriate case management, which those receiving long term care services and supports (LTSS) entering managed long term care will have. Currently, only those in certain waiver programs or already in managed care and receiving LTSS have access to comprehensive care management to assure that an individual's needs are met in the most efficient and effective manner possible. Appropriate case management has been shown to reduce re-hospitalization and emergency room utilization and to maximize positive health outcomes for the individual.

Under New York's Care Management for All efforts, care management will occur at the plan level. This means individuals will be given the opportunity to choose a managed care or managed long term care plan if he or she is Medicaid eligible and functionally eligible for LTSS. The state has a contract with Maximus to provide such individuals with assistance in choosing an appropriate MC/MLTC plan in mandatory managed care counties. Through its participation in BIP, New York State will implement a self-assessment that any individual can complete to help determine his or her eligibility for LTSS, which will help ensure that the consumer is well-informed to make an appropriate decision about his or her plan options. The State already has a web-based self -assessment for Medicaid eligibility that will be included in the resources made available to the individual. Through the enhanced NY Connects process, the individual will be referred to an enrollment broker (Maximus) to enroll in a plan that will meet the needs identified through the self-assessment.

Once an individual is enrolled in a plan, he or she will be given a comprehensive assessment (UAS-NY) and be guided through a person-centered care planning process based on the results. The individual conducting the assessment will be required to attest to his or her freedom from conflict in conducting these tasks. In addition, the use of an automated universal assessment will reduce the likelihood of conflict between qualifying for services and supports and the provision of such needed services. By providing individuals with the resources to self-assess to determine whether or not they are eligible for LTSS, they will have choice in selecting a MC/MLTC plan. From there, a third party (the enrollment broker, Maximus) will guide them and there will be no lock-in for those with both Medicare and Medicaid, and they have grievance, appeal and fair hearing rights to challenge service decisions. New York State plans to investigate additional mechanisms to assure the provision of LTSS under BIP is conflict-free by requiring documentation of consumer choice of plans and providers, post- enrollment reviews of the assessment and care planning process with an eye toward minimizing conflicts. In addition, the state will document the number and type of appeals and decisions arising under this context, take steps to reduce conflict of interest that may arise as a result of managed care/managed long term care plans conducting assessments and developing plans of care.

OPWDD has designed several system components for its future managed care operations to ensure no conflict of interest in service planning. These measures use a variety of approaches to separate case management from fiscal decisions, implement enhanced quality management, strengthen state oversight and implement administrative firewalls. As part of its work plan development New York State will look at implementing these safeguards throughout our LTSS system.

Finally, as part of its work plan development, the state will determine specific outcomes and quality measures to assess the care planning and assessment process to inform requirements and policies that result in a conflict free assessment and care planning process.

Section J. Staff Qualifications and Training

New York State has developed a comprehensive staff qualification and training program for the UAS-NY. This program was developed to provide, in one location, all of the information users need to learn about and effectively use the UAS-NY. The UAS-NY Training Environment is fully online. All of the courses in the training environment are self-paced and available 24/7.

Prior to accessing the UAS-NY Training Environment, organizations must ensure that staff has a basic level of proficiency using computers and web-based systems. Additionally, staff who is assigned the responsibility for conducting assessments must meet the minimum guidelines and have the requisite experience for conducting health-related assessments.

OPWDD will require that individuals who complete the functional assessment (OPWDD's CAS) are qualified developmental disability professionals (QDDP) and that they are trained in the administration of the CAS. Training of the initial cohort of OPWDD assessors has occurred with the support of staff from InterRAI/University of Michigan.

New York State will investigate the current staff qualifications and training requirements for assessors and managers in other tools used in the state as part of its final work plan.

Section K. Location of SEP Agencies

As noted above, New York State plans to network its existing access points into a NWD/SEP system that ensures that no matter what door a consumer enters, he or she will receive consistent information about his or her LTSS options and will receive assistance, to the extent needed, to determine functional and financial eligibility and become enrolled in appropriate services. These access points are accessible to individuals across the state and cover the entire population. As part of its final work plan submission, New York State will finalize a list of SEPs.

Section L. Outreach

NYS will capitalize on its strengths and ensure that people are aware of what is available, use CFC and other initiatives to break down silos of care and integrate services across populations. Key to ensuring that consumers have improved access to necessary LTSS will be making sure that discharge planners, social workers, nurses, physicians and other common referral sources are aware of the new interface that BIP participation will allow New York State to develop to ensure that consistent LTSS information and assistance is available across the state. This will involve a considerable outreach effort.

New York State offers such an array of LTSS currently and already has systems in place to assist individuals with eligibility determinations and enrollment into appropriate services and programs. However, these resources are not consistent across the state and often people don't know they exist. BIP participation will use a considerable provider network and other existing channels of communication with the home and community-based services community to fully develop and distribute comprehensive and consistent information about LTSS across the state.

In addition to providing information to the access points that reflects state-wide opportunities for LTSS across all Medicaid supported populations, it will be necessary to ensure that NY Connects is seen as the portal to LTSS for all individuals in the state in need of this information. As part of its BIP participation, New York State will develop a comprehensive strategy to ensure that relevant populations are aware of the new capacity built into NY Connects.

New York will build on the many efforts underway in the state to improve access to needed services. For example, OPWDD has conducted extensive outreach to and engagement of its many stakeholders throughout the process of identifying and defining the needed service system reforms incorporated in the People First Waiver. This waiver initiative will achieve many critical reforms related to service access and integration of cross-systems care through the transformation of the service system from fee-for-service to managed care in parallel with key improvements to OPWDD's "front door," needs assessment, person-centered planning, quality assurance practices and service menu enhancements and the associated information technology development.

The OPWDD People First Waiver Web page documents the full sequence of stakeholder design teams, steering committee, work teams, public forums and surveys that OPWDD has deployed to communicate about and involve outside parties in the developing reform initiative:

http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/home.

Section M. Data Collection and Reporting Requirements

Services Data

New York will collect service and recipient data using several data sources that encompass both fee-for-service and managed care per member per month (PMPM) arrangements. The Medicaid data warehouse captures expenditures from provider billings that are reconcilable with the service categories on the quarterly CMS 64 reports will be used. The cost reports filed with NYS by managed long term care plans for rate setting reveal the ratios of institutional and acute care costs which can be applied and subtracted from capitated payments for MLTC plans captured in the Medicaid data warehouse. The portion of home and community based services (HCBS) expenditures made to mainstream managed care plans for aged and disabled recipients will be compiled using the 1115 waiver supplements submitted with the quarterly CMS 64's reports.

The data sources and general methodology for capturing and compiling the HCBS expenditure and recipient data on a quarterly basis will be as follows:

- **Home & Community Based fee-for-service providers** - Expenditures and recipient counts will be extracted from the Medicaid data warehouse using categories of service defined for analytical purposes and reconcilable to the quarterly CMS 64 reports. The Salient application will be used to extract the data.
- **MLTC Plans** - Per capita expenditures and recipient counts will be extracted from the Medicaid data warehouse. The per capita expenditures will be adjusted for the institutional and other expenditures not defined as long-term portions as calculated from the annual cost reports filed by MLTC plans.
- **Mainstream Managed Care plans** - The HCBS expenditures for the aged and disabled populations served by mainstream managed care plans will be compiled using the 1115 waiver supplements filed with the quarterly CMS 64 reports. The expenditure amounts on the service lines associated with HCBS expenditures (i.e. personal care) will be combined for the eligibility categories associated with the aged and disabled populations.
- **Health Homes** - Expenditures attributable to health homes for recipient's care coordination will be captured using the Medicaid data warehouse and selection criteria defined in Salient.

Data sources and methodologies may be updated as OPWDD and other fee-for-service programs evolve to Managed Care.

The general protocol for collecting the service data each quarter will be as follows:

1. All of the HCBS programs will be evaluated for significant changes that may require revisions to the data collection protocol, sources, or methods in order to capture expenditures and recipient data.
2. Data will be extracted and compiled as described above or as revised for significant changes identified in step 1.
3. Data collected for each quarter will be compared to previous quarters, validated and analyzed.
4. Data collected will be reconciled with the CMS 64 reports.

Quality Data

NYS will identify a subset of Medicaid Adult Health Quality Measures in consonance with Section 2701 of the Affordable Care Act and consistent, where possible, with those which have already been identified for the requirements under the Partnership and F-SHRP 1115 waivers. For the screening, quality data will be considered for collection for potential BIP participants. This may include NWD/SEP screen data, and information from the self-assessment. This will enable New York to begin tracking potential BIP recipients from the point of entry in the system, beginning with NY Connects. Following the comprehensive assessment process, quality data will be collected for BIP recipients by leveraging the data sources, programming resources, and processes that have already been planned or developed for the managed care, managed long term care and Health Homes.

Outcomes Measures

Currently some New York State programs and demonstrations use several different quality of life satisfaction surveys. While there are major efforts underway to use common outcomes measures from comprehensive interRAI assessments by DOH and OPWDD, not all populations are included and implementation timelines are different in some cases. Additionally, there are measures that may be applicable and useful within the BIP Initiative; some have been developed for non-Medicaid service recipients and caregivers that have been field tested (e.g., Administration for Community Living/Administration on Aging's Performance Outcomes Measurements Project) and measures such as the Council on Quality Leadership's Personal Outcome Measures have been used for both Medicaid and non-Medicaid populations.

New York State will use a combination of quality of life surveys and assessment data to collect outcome measures in order to assess beneficiary and family caregiver satisfaction with providers as well as assess activities that help individuals achieve higher quality of life, including employment, self-direction, participation in community life, health stability, and prevention of loss in function.

New York State will collect information about the various tools and processes to identify gaps in order to determine the most efficient protocol(s) for collecting outcome measures by population with the following goals:

- Each individual/caregiver covered under BIP has a chance to be selected for a satisfaction survey;
- Each individual/caregiver covered under BIP has a assessment with outcomes that can help individuals achieve a higher quality of life;
- The final outcomes for satisfaction surveys and comprehensive assessments:
 - complement one another;

- are not redundant;
- will be meaningful and actionable by providers and NYS;
- The data collection processes consider:
 - The frequency of surveys and assessment cause minimum imposition on individuals/caregivers while maximizing actionable outcomes;
 - The timing of surveys cause outcomes which can be fairly associated with particular providers or programs;
 - Automation that captures data which can be associated with individuals/caregivers longitudinally;
- Can be improved and made more standard over time.

Data Reporting

New York State will submit a work plan on 9/1/2013 and quarterly progress reports and financial data six weeks after the end of each quarter, including the quarter during which the work plan was approved.

Section N. Funding Plan

New York State is committed to implementing an enhanced NY Connects system to comply with the requirements of BIP and improve access to and expand the capacity of our extensive home and community based long term care system. Individuals across all populations will use this system to learn about their options and to determine their potential eligibility for various LTSS to assist them with their LTSS needs. This will ensure consistent information across the state and across agency programs and services and will ensure that as New York migrates to a "Care Management for All" LTSS system all individuals with functional, behavioral and/or medical LTSS needs are aware of their options and have access to needed services.

The funding plan in Appendix B illustrates state projections of its spending on LTSS during the funding period. These projections are based on several reform efforts including cost growth containment efforts and the MRT "Care Management for All" initiative. They also assume that the state will participate in the Community First Choice Option under the Affordable Care Act, section 2401 (section 1915(k)) of Title XIX of the Social Security Act) beginning October 1, 2013 and that health homes expenditures will increase by 10% per year during the funding period.

NYS already spends billions of dollars in State funds to match Medicaid services and tens of millions to support NYSOFA programs and services. In addition, New York State has earmarked \$79 million for supportive housing, \$10 million to support BIP implementation, \$4.8 million for UAS-NY enhancements, and \$3.35 million in NY Connects funding in the proposed 2013-14 Executive Budget.

The rebalancing activities which will allow NYS to achieve the 50% benchmark in 2015 include transitioning people from institutions, adjusting rates to incent case management, increasing HCBS capacity, implementing CFCO, deploying a uniform diversion process and addressing work force shortages. These activities will be funded through enhanced FMAP from BIP and CFCO, MFP rebalancing funds, various state appropriations, and NYSOFA program funding and grants.

The structural changes including implementing the NWD/SEP system, core standardized assessment, and conflict free case management will be supported by MFP administrative funds, CFCO FMAP, and various NYS appropriations.

The chart in Appendix C depicts the specific activities related to rebalancing and structural changes, together with the particular funding and BIP year.

Section O. Challenges

As noted above, New York State's greatest challenge is making it easier for consumers to understand their options and access needed home and community based services quickly and consistently in all parts of the state. BIP will allow the development and implementation of a resource that ties together the array of programs and services offered to those in need of LTSS and ensure seamless access at the consumer level.

New York is undergoing major reform efforts currently as a result of the MRT recommendations and this presents certain challenges. However, the goals of BIP and those of Care Management for All are consistent and pursuing them together, along with other significant health care reforms that meet the CMS triple aim, are mutually supportive and consistent.

In order to operationalize this enhanced NY Connects, the Department of Health (the State's Medicaid Agency) will work with its sister agencies (NYSOFA, OPWDD, OMH and OASAS) to develop protocols ensuring that regardless of an individual's diagnosis or disability or where that individual goes for assistance, he or she is presented consistent information about the full range of options for LTSS in the community. The Department will work with our sister agencies and stakeholders to develop protocols, standards and other tools to assist in assuring consistent, complete, coherent and comprehensive guidance to those seeking LTSS. This information will be available in all SEPs established under BIP so that individuals seeking assistance and/or information about their LTSS options will have access to timely, appropriate and compliant information. The NWD website and 1-800 number will facilitate the provision of information in a variety of the most popularly spoken languages in the state. The Department of Health will establish MOUs or other agreements with our sister agencies to assure that Medicaid funds are used consistent with our BIP work plan objectives to rebalance at least 50% of state expenditures on LTSS provided in appropriate home and community based settings.

In addition, New York's anticipated participation in the Community First Choice Option (CFCO) will assure that many community based LTSS are available through the state plan to address the needs identified in a person-centered care planning process to maximize an individual's independence and integration in the community. BIP will assure that all individuals who are eligible for CFCO services are aware of this option and maximize participation in this program to improve access to enhanced personal attendant services and supports.

New York State agencies are actively engaged in monitoring stakeholder feedback on the delivery of community based long term care services and supports. Among these activities are the regular reports of the local Long Term Care Councils established as part of the NY Connects system. These councils are representative of populations served and include local area agencies on aging, local social services districts, other county agencies, independent living centers, health and home care providers, consumers, caregivers and other stakeholders with a vested interest in the accessibility and availability of community based LTSS. OPWDD has also undertaken a statewide stakeholder engagement process as it developed its People First Waiver to improve the delivery of community based LTSS to the ID/DD population.

Through this process of stakeholder engagement, the following gaps have been identified as barriers to greater community based care:

- People who would prefer community based care remain in institutional settings;

- Insufficient supply of safe, affordable and accessible housing and the services and supports to maintain individuals in the community;
- Inconsistent availability and accessibility of services;
- Insufficient transportation options/accessible transportation, especially upstate;
- Inability to consistently identify potential diversions across agencies;
- Insufficient workforce;
- Inadequate coordination and collaboration; fragmented services;
- Fragmented system administrations;
- Inadequate opportunity for individual voice and/or choice in determining needed services; and
- Providers are involved in the assessment and care planning processes.

The chart in Appendix C details how New York State intends to address these gaps through its participation in BIP and other rebalancing efforts.

Section P. NWD/SEP's Effect on Rebalancing

As set forth in Section N and Appendix C, New York State anticipates that after the program payment period, state funds expended on LTSS home and community based services compared to institutional services will exceed the goal of 50%.

Section Q. Other Balancing Initiatives

BIP is consistent with New York's considerable efforts to rebalance the proportion of expenditures on LTSS in the community over the past several decades. As described above, New York has achieved significant success in providing needed services in home and community based settings across the state, regardless of an individual's diagnosis or condition.

New York has a long history of supporting community living as an alternative to institutional care. For example, in the past 35 years OPWDD significantly reduced the number of institutional placements and replaced it with a large, statewide network of community living options, including community residences and individually controlled residential supports. The number of people with intellectual and developmental disabilities served in community based services has grown over 500%, from 1975 to 2011. These opportunities were created to address the desire of people with developmental disabilities and their families for living arrangements in and outside of the family home. OPWDD is committed to maintaining a full array of residential support options to meet the needs of individuals, their families and advocates and, through the People First Waiver reforms, moving the system forward toward more individualized service options that respond with coordinated supports and services to meet the full range of a person's identified support needs.

OPWDD has committed to further reducing the use of institutional settings to deliver services. Within the People First Waiver, the agency is articulating milestones for ultimately eliminating institutional settings. To achieve this goal, OPWDD will devote resources to develop alternative, community-based clinical services that can address the most extreme levels of need for long-term support while ensuring health and safety. OPWDD is further committed to expanding the array of residential support options that are available to meet the needs of individuals with new levels of support that fall between full, 24/7 supervision and total independence, to more appropriately match individuals' needs.

Section R. Technical Assistance

New York will work with its considerable network of stakeholders and state partners to determine what areas of BIP compliance will require technical assistance as we develop the final work plan to be submitted within six months of application approval.

Appendix A – Letters of Support



State of New York
Andrew M. Cuomo
Governor



Office of Mental Health
44 Holland Avenue
Albany, New York 12229
www.omh.ny.gov

December 18, 2012

Mr. Jason Helgeson, Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza, 20th Floor
Albany, New York 12210

Dear Director Helgeson:

I am writing this letter in support of the New York State Department of Health's application to participate in the federal Balancing Incentive Program (BIP) authorized in the Affordable Care Act (P.L. 111-148, §10202).

We look forward to working with the Department in its efforts to expand access and improve coordination to Long Term Services and Supports (LTSS) across all populations in the state. We believe that the goals of BIP will improve the balance of community based LTSS, and improve consumer and family satisfaction.

New York's efforts to date to improve the integration of individuals in home and community based settings will be aided through participation in BIP to ensure that these essential services are provided in the most effective and least restrictive settings. Leveraging federal resources to streamline eligibility, improve access and expand community-based LTSS across all populations will complete New York's long standing rebalancing goals.

This organization supports the submission by the Department and looks forward to continued collaboration to meet the goals of BIP.

Sincerely,

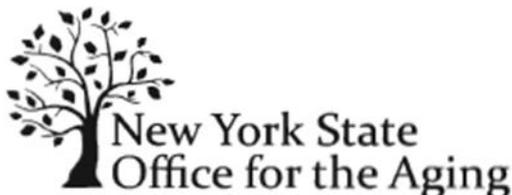
A handwritten signature in black ink that reads "Kristin M. Woodlock".

Kristin M. Woodlock, RN, MPA
Acting Commissioner



Andrew M. Cuomo
Governor

Greg Olsen
Acting Director



Two Empire State Plaza
Albany, New York
12223-1251

www.aging.ny.gov

December 18, 2012

Mr. Jason Helgeson, Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza, 20th Floor
Albany, New York 12210

Dear Director Helgeson:

I am writing this letter in support of the New York State Department of Health's application to participate in the federal Balancing Incentive Program (BIP) authorized in the Affordable Care Act (P.L. 111-148, §10202).

The New York State Office for the Aging (NYSOFA) has been working closely with the Department on a number of initiatives to better coordinate and integrate long term services and supports and increase access including developing and implementing our state's ADRC (NY Connects), participating on the Community First Choice Option workgroup, participating in the state's Olmstead implementation work through the Most Integrated Setting Coordinating Council, building statewide capacity to implement Chronic Disease Self Management Education (CDSME) as well as partnerships to expand capacity at the community level through the states proposed 1115 waiver and Center for Medicare and Medicaid Innovation grant.

NYSOFA looks forward to working with the Department in its efforts to expand access and improve coordination to Long Term Services and Supports (LTSS) across all populations in the state. Through NYSOFA's network of 59 area agencies on aging, over 1,200 community-based contractors and partners, and 1,600 local long term care council members, we believe that we can play an important role in helping the Department meet the goals of BIP, improve the balance of community-based LTSS, and improve consumer and family satisfaction.

New York's efforts to date to improve the integration of individuals in home and community-based settings will be aided through participation in BIP to ensure that these essential services are provided in the most effective and least restrictive settings. Leveraging federal resources to streamline eligibility, improve access and expand community-based LTSS across all populations will complete New York's long standing rebalancing goals.

NYSOFA strongly supports the submission by the Department and looks forward to continued collaboration to meet the goals of BIP.

Sincerely,

Greg Olsen

Promoting independence and quality of life
for older New Yorkers



Senior Citizens' Help Line 1-800-342-9871
An Equal Opportunity Employer



Andrew M. Cuomo, Governor
Courtney Burke, Commissioner

Executive Office

44 Holland Avenue
Albany, NY 12229-0001

TEL: 518-473-1997

FAX: 518-473-1271

TTY: 866-933-8889

www.opwdd.ny.gov

December 19, 2012

Mr. Jason Helgeson, Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza, 20th Floor
Albany, NY 12210

Dear Director Helgeson:

I am writing this letter in support of the New York State Department of Health's application to participate in the federal Balancing Incentive Program (BIP) authorized in the Affordable Care Act (P.L. 111-148, §10202).

The New York State Office for People With Developmental Disabilities (OPWDD) looks forward to working with the Department of Health in its efforts to expand access and improve coordination to long term services and supports (LTSS) across all populations in the state. We believe that the goals of BIP will improve the balance of community-based LTSS, and improve satisfaction for individuals and families.

New York's efforts to date to improve the integration of individuals in home and community-based settings will be aided through participation in BIP to ensure that these essential services are provided in the most effective and most integrated settings. Leveraging federal resources to streamline eligibility, improve access, and expand community-based LTSS across all populations will complete New York's long-standing rebalancing goals.

OPWDD supports the submission by the New York State Department of Health and looks forward to continued collaboration to meet the goals of BIP.

Sincerely,

Courtney Burke

Appendix B - Applicant Funding Estimates

Appendix B								
DEPARTMENT OF HEALTH & HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES BALANCING INCENTIVE PAYMENTS PROGRAM (Balancing Incentive Program) APPLICANT FUNDING ESTIMATES LONG TERM SERVICES AND SUPPORTS								
State	New York				State FMAP Rate	50%		
Agency Name	Department of Health				Extra Balancing Incentive Program Portion (2 or 5 %)	2%		
Quarter Ended								
Year of Service (1-4)	FFY 13-15							
					Projected LTSS Spending			
LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded By Balancing Incentive Program (4 year total)	Year 1	Year 2 4/1/13-9/30/13	Year 3 10/1/13-9/30/14	Year 4 10/1/14-9/30/15
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Home Health Services- State Plan	598,674,856	299,337,428	299,337,428	11,973,497		252,773,828	212,862,171	133,038,857
Line 18A- Medical Health Insurance Payments: Managed Care Organizations (MCO)- non-institutional portion (Includes CFCO)	11,408,378,296	5,704,189,148	5,704,189,148	228,167,566		1,938,939,197	4,525,589,581	4,943,849,518
Line 19A- Home and Community Based Services- Regular Payment Waiver:	-	-	-	-				
OPWDD Waiver	14,505,586,099	7,252,793,050	7,252,793,050	290,111,722		2,818,919,235	5,773,843,314	5,912,823,550
LTHHCP (incl. State plan home care inside the LTHHCP)	434,871,369	217,435,685	217,435,685	8,697,427		246,566,199	141,213,190	47,091,979
NHTD & TBI	492,250,439	246,125,220	246,125,220	9,845,009		98,450,088	196,900,176	196,900,176
CAH , B2H	369,539,941	184,769,971	184,769,971	7,390,799		73,907,988	147,815,977	147,815,977
Line 23A- Personal Care Services- Regular Payment	2,038,993,894	1,019,496,947	1,019,496,947	40,779,878		860,908,533	724,975,607	453,109,754
Line 43- Health Homes for Enrollees with Chronic Conditions	84,980,081	42,490,040	42,490,040	1,699,602		25,673,740	28,241,114	31,065,226
TOTALS	29,933,274,975	14,966,637,488	14,966,637,488	598,665,500			6,316,138,809	11,751,441,130

Appendix C – Rebalancing Activities

New York State Rebalancing Activities

Gaps or Issues	Activity or Resolutions	BIP Year 2 4/1/13- 9/30/13	BIP Year 3 10/1/13- 9/30/14	BIP Year 4 10/1/14- 9/30/15	Sources/Resources	Notes
REBALANCING ACTIVITIES:						
There are people in institutions who would be served more appropriately in home & community-based settings across all agencies:	<ul style="list-style-type: none"> Execute transitions across agencies 	✓	✓	✓	<ul style="list-style-type: none"> * BIP-Enhanced FMAP * MFP for Rebalancing 	
	<u>Adjust Rates to Incent:</u> <ul style="list-style-type: none"> Case management in MLTC for OMH and DOH agency populations Deinstitutionalization during mandatory MC/MLTC enrollment Transitioning those with high needs Plan development in rural areas Plan development in DD populations 	✓	✓	✓	<ul style="list-style-type: none"> * BIP-Enhanced FMAP * State Appropriations 	
Lack of affordable, safe, accessible housing across populations. Lack of other supports and services:	<ul style="list-style-type: none"> Increase OPWDD HCB Capacity (housing and services) <p><i>i.e. training family members, new types of residential supports, increase opportunities for self direction, expanding access to supported employment.</i></p>	✓	✓	✓	<ul style="list-style-type: none"> * BIP-Enhanced FMAP (services) * MFP for Rebalancing (services) * State Appropriations (supportive housing) * NYSOFA Grants and Other Funding 	

Gaps or Issues	Activity or Resolutions	BIP Year 2 4/1/13- 9/30/13	BIP Year 3 10/1/13- 9/30/14	BIP Year 4 10/1/14- 9/30/15	Sources/Resources	Notes
	<ul style="list-style-type: none"> • Increase affordable, safe, accessible housing for all populations • Continue Accessible Housing Registry initiative • Continue MRT Affordable Housing Workgroup • Expand activities under MFP’s TRAIID program; number of loans for assistive technology for those in a pending status 	✓	✓	✓	<ul style="list-style-type: none"> * State Appropriations (supportive housing, HCR) * MFP for Rebalancing (services) 	
Uneven Service Accessibility and Availability:	<ul style="list-style-type: none"> • Implement CFCO to streamline service silos and increase access to home and community based service options. 		✓		* CFCO- Enhanced FMAP	
	<ul style="list-style-type: none"> • Increase caregiver support services • Supporting families more effectively 	✓	✓	✓	<ul style="list-style-type: none"> * NYSOFA Grants and Other Funding * BIP 	
	<ul style="list-style-type: none"> • Continue to support community long term care councils and work groups 	✓	✓	✓	* NYSOFA Funding	
	<ul style="list-style-type: none"> • Continue MRT initiatives/workgroups: <ul style="list-style-type: none"> ○ Behavioral Health Reform (accessing LTSS) ○ Care Management for All 				* NYS Appropriations	
Lack of transportation options and/or wheelchair	<ul style="list-style-type: none"> • Increase transportation options in upstate counties. 	✓	✓	✓	* NYSOFA Grants and Other Funding	

Gaps or Issues	Activity or Resolutions	BIP Year 2 4/1/13- 9/30/13	BIP Year 3 10/1/13- 9/30/14	BIP Year 4 10/1/14- 9/30/15	Sources/Resources	Notes
accessible transportation not available in upstate counties:						
There is no uniform process to address diversions across agencies:	<ul style="list-style-type: none"> • Enhance evidence based criteria to identify those at risk for institutional placements • Deploy uniform process across all agencies • Develop interagency protocols 		✓	✓	* NYS Appropriations (UAS-NY)	
Lack of direct care workers:	<ul style="list-style-type: none"> • Continue collaborations, educational forums, career ladder structuring activities, training, etc. in regions and organizations • Training family members • Improve training and other supports • Supporting families more effectively • Continue MRT initiatives/workgroup: <ul style="list-style-type: none"> ○ Workforce Flexibility & Change in Scope of Practice 	✓	✓	✓	<ul style="list-style-type: none"> * BIP Funding * NYSOFA Funding and Grants * NYS Appropriations 	* MRT workforce recommendations are contained in the 2013/14 Executive budget
NWD/SEP:						

Gaps or Issues	Activity or Resolutions	BIP Year 2 4/1/13- 9/30/13	BIP Year 3 10/1/13- 9/30/14	BIP Year 4 10/1/14- 9/30/15	Sources/Resources	Notes
Need more Coordination and Collaboration. Silos fragment system administration:	<ul style="list-style-type: none"> Expand NY Connects and add features – Make Statewide 				<ul style="list-style-type: none"> * BIP Enhanced FMAP * NYS Appropriations 	
Need more Coordination and Collaboration. Silos fragment system administration (cont.):	<ul style="list-style-type: none"> Website Self-assessment Assessment Process Long Term Care Resource directory 	✓	✓	✓	<ul style="list-style-type: none"> * Enhanced FMAP * NYS Appropriations * NYSOFA funding 	
	<ul style="list-style-type: none"> Public awareness 		✓		<ul style="list-style-type: none"> * NYS Appropriations 	
	<ul style="list-style-type: none"> Support robust usage of UAS-NY 		✓	✓	<ul style="list-style-type: none"> * MFP for Administrative Activities * NYS Appropriations (UAS-NY) 	<ul style="list-style-type: none"> * Laptops and notepads * System Evolution
	<ul style="list-style-type: none"> Develop interagency protocols 	✓	✓	✓		
CORE STANDARDIZED ASSESSMENT:						
Silos fragment system administration:	<ul style="list-style-type: none"> Support robust usage and expand use of UAS-NY 		✓	✓	<ul style="list-style-type: none"> * MFP for Administrative Activities * NYS Appropriations 	<ul style="list-style-type: none"> * Laptops and notepads * System Evolution
Need to strengthen the voice of the individual: Need to reinforce choice:	<ul style="list-style-type: none"> Implementing standardized comprehensive, person centered assessment and care planning process that looks at strengths and interests as well as need Develop interagency protocols 		✓	✓	<ul style="list-style-type: none"> * MFP for Administrative Activities * CFCO FMAP * NYS Appropriations 	

Gaps or Issues	Activity or Resolutions	BIP Year 2 4/1/13- 9/30/13	BIP Year 3 10/1/13- 9/30/14	BIP Year 4 10/1/14- 9/30/15	Sources/Resources	Notes
CONFLICT FREE CASE MANAGEMENT:						
Conflicted duties are not always separated:	<ul style="list-style-type: none"> • OPWDD system design features: <ul style="list-style-type: none"> ○ Separate Case Mgmt. from fiscal decisions ○ Implement enhanced quality management ○ strengthen oversight and implement administrative firewalls 	✓	✓	✓	* NYS Appropriations	
Conflicted duties are not always separated (cont.):	<ul style="list-style-type: none"> • Continue to implement “Care Management for All” with conflict free features: <ul style="list-style-type: none"> ○ Incented by PMPM reimbursement methodology ○ Predetermined functional eligibility ○ Use of contractual terms and conditions ○ Strengthen oversight 	✓	✓	✓	* NYS Appropriations	
	<ul style="list-style-type: none"> • Develop interagency protocols 	✓	✓	✓	* NYS Appropriations	
REPORTING AND DATA COLLECTION:						
	<ul style="list-style-type: none"> • Final Work Plan 	✓			* NYS Appropriations	
	<ul style="list-style-type: none"> • Quarterly Progress Reporting 		✓	✓	* NYS Appropriations	
	<ul style="list-style-type: none"> • Data Collection 	✓	✓	✓	* NYS Appropriations	

Appendix D – New York State Executive Order No. 84

Establishing the New York State Olmstead Plan Development and Implementation Cabinet



ESTABLISHING THE OLMSTEAD PLAN DEVELOPMENT AND IMPLEMENTATION CABINET

WHEREAS, the United States Supreme Court held in *Olmstead v. L.C.*, 527 U.S. 581 (1999), that Title II of the Americans with Disabilities Act prohibits the unjustified segregation of people with disabilities and requires states to provide people with disabilities with necessary support and services in the most integrated setting appropriate to their needs;

WHEREAS, the Olmstead court recognized that unnecessary institutional placement can isolate people with disabilities and severely diminish their family relations, social contacts, employment options, economic independence and educational advancement;

WHEREAS, the State of New York is committed to the principle that people with disabilities should have access to community-based services, accessible housing with appropriate supports, and employment opportunities that enable them to live productive lives in their communities;

WHEREAS, all New Yorkers with disabilities and their families should have the opportunity to make informed choices regarding services, settings and related issues;

WHEREAS, the State of New York has taken important steps to strengthen community-based supports for people with disabilities, including accelerated access to care management that better addresses individual needs; and the creation of health homes that provide integrated care coordination for complex populations, including people with disabilities;

WHEREAS, the State of New York continues to fulfill its commitment to people with disabilities, through the inclusion of a supportive housing initiative and funding for supported housing in the State Fiscal Year 2012-13 Executive Budget; and

WHEREAS, it is critically important for the State of New York to develop and implement a comprehensive Olmstead Plan on behalf of all of New York's children and adults with disabilities;

NOW, THEREFORE, I, Andrew M. Cuomo, Governor of the State of New York, by virtue of the authority vested in me by the Constitution and laws of the State of New York, do hereby order as follows:

A. Definitions

As used herein, the following terms shall have the following meanings:

1. "State agency" or "agency" shall mean any state agency, department, office, board, bureau, division, committee, council or office.
2. "Authority" shall mean a public authority or public benefit corporation created by or existing under any New York State law, with one or more of its members appointed by the Governor or who serve as members by virtue of holding a civil office of New York State, other than an interstate or international authority or public benefit corporation, including any subsidiaries of such public authority or public benefit corporation.

B. Olmstead Plan Development and Implementation Cabinet

1. There is hereby established the Olmstead Plan Development and Implementation Cabinet (the "Cabinet") to provide guidance and advice to the Governor.
2. The Cabinet shall be comprised of the Governor's Deputy Secretary for Health/Director of Healthcare Redesign; the Counsel to the Governor; the Director of the Budget; the Commissioner of Developmental Disabilities; the Commissioner of Health; the Commissioner of Labor; the Commissioner of Transportation; the Commissioner of Mental Health; the Commissioner of Alcoholism and Substance Abuse Services; the Commissioner of Children and Family Services; the Commissioner of Homes and Community Renewal; the Commissioner of Temporary and Disability Assistance; the Director of the State Office for the Aging; and the Chair of the Commission on Quality of Care and Advocacy for Persons with Disabilities. Additional members may be appointed to the Cabinet at the discretion of the Governor.
3. The Governor shall appoint the Chair of the Cabinet from among the members of the Cabinet.
4. Each member of the Cabinet may designate a staff member to represent him or her and participate in the Cabinet on his or her behalf. The Cabinet shall meet at the call of the Chair as often as is necessary and under circumstances as are appropriate to fulfill its duties under this section

C. Cooperation with the Cabinet

1. Each agency and authority of the State of New York shall provide to the Cabinet such information, assistance and cooperation, including use of State facilities, which is reasonably necessary to accomplish the purposes of this Order.

2. Staff support necessary for the conduct of the Cabinet's work may be furnished by agencies and authorities (subject, as necessary, to the approval of the board of directors of such authorities).

D. Duties and Purposes

1. The Cabinet shall make recommendations to the Governor concerning the development, implementation and coordination of an Olmstead Plan (the "Plan") for the State of New York. In making such recommendations, the Cabinet shall consider potential elements of the Plan, including but not limited to:

- a. identification of the essential requirements of compliance with Olmstead and the Americans with Disabilities Act;
- b. assessment procedures to identify people with disabilities who could benefit from services in a more integrated setting and the development of a coordinated assessment process for individuals of all ages with disabilities in need of services;
- c. measurable progress goals for achieving integrated residential living, including transition goals from segregated to residential housing, and employment opportunities for people with disabilities;
- d. measurable goals for providing supports and accommodations necessary for successful community living;
- e. statutory and regulatory changes to implement the Plan;
- f. a coordination strategy for the work of state agencies and authorities to implement the Plan, including specific and reasonable timeframes for implementation;
- g. actions to promote community understanding of and support for integrated residential living for people with disabilities;
- h. other appropriate measures to achieve and implement a comprehensive and unified Plan; and
- i. how best to maximize available resources in support of the Plan.

2. In developing recommendations for the development of the Olmstead Plan and its implementation and coordination, the Cabinet shall consult with the Most Integrated Setting Coordinating Council and other relevant entities and stakeholders concerned with development and implementation of the Olmstead Plan.

3. In carrying out its responsibilities under this Order, the Cabinet shall seek the guidance and expertise of stakeholders, including, but not limited to, organizations that advocate on behalf of people with disabilities, providers of services to people with disabilities, associations concerned with housing and employment for people with disabilities, academic institutions and local governments, and shall solicit input from the public.

4. The Cabinet shall commence its work immediately. On or before May 31, 2013, the Cabinet shall submit a final report to the Governor, setting forth its recommendations concerning establishment, implementation and coordination of the Olmstead Plan, at which time the Cabinet shall terminate its work and be relieved of all responsibilities and duties hereunder. Prior to such date, the Board shall issue additional reports to the Governor of its activities, findings, recommendations and coordination in furtherance of the purposes of this Order from time to time as directed by the Governor or the Governor's designee.

G I V E N under my hand and the Privy Seal of the State in the City of Albany this thirtieth day of November in the year two thousand twelve.

BY THE GOVERNOR

Secretary to the Governor